STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

TITLE 28, CALIFORNIA CODE OF REGULATIONS
DIVISION 1. THE DEPARTMENT OF MANAGED HEALTH CARE
CHAPTER 2. HEALTH CARE SERVICES PLANS
ARTICLE 8. SELF-POLICING PROCEDURES

PROPOSED ADOPTION OF SECTION 1300.71.39 AND
REVISION OF SECTION 1300.71.38

PROPOSED TEXT
Control No. 2006-0777

*Adopt new section 1300.71.39 as follows:*

§ 1300.71.39. Unfair Billing Patterns

(a) Unfair billing patterns and practices as defined in Section 1371.39 and this section are prohibited.

(b) Except for services subject to the requirements of Section 1367.11 of the Act, "unfair billing pattern" includes the practice, by a provider of emergency services, of billing an enrollee of a health care service plan for amounts owed to the provider by the health care service plan for the provision of covered services.

(1) Co-payments, coinsurance and deductibles that are the financial responsibility of the enrollee are not amounts owed the provider by the health care service plan.

(2) An emergency services provider who provides emergency services to an enrollee of a health care service plan may not collect or attempt to collect from the enrollee any amount due to the provider by the health plan, and instead must seek reimbursement directly from the health care service plan for the provision of covered services.

Authority: Sections 1344, 1371.38, 1371.39, 1371.4, Health and Safety Code.
Reference: Sections 1342, 1345, 1346, 1367(h), 1371, 1371.1, 1371.35, 1371.36, 1371.38, 1371.39, 1371.4 and 1379, Health and Safety Code.

*Revise section 1300.71.38 as follows:*

§ 1300.71.38. Fast, Fair and Cost-Effective Dispute Resolution Mechanism

All health care service plans and their capitated providers that pay claims (plan's capitated provider) shall establish a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes. The plan and the plan's capitated provider may maintain separate dispute resolution mechanisms for contracted and non-contracted provider disputes and separate dispute resolution mechanisms for claims and other types of billing and contract disputes, provided that each mechanism complies with sections 1367(h), 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28. Arbitration shall not be deemed a provider dispute or a provider dispute resolution mechanism for the purposes of this section.

(a) Definitions:

(1) "Contracted Provider Dispute" means a contracted provider's written notice to the plan or the plan's capitated provider challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute (or a bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim that contains, at a minimum, the following information: the provider's name; the provider's identification number; contact information; and:

(A) If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item, the date of service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect;

(B) If the dispute is not about a claim, a clear explanation of the issue and the provider's position thereon; and

(C) If the dispute involves an enrollee or group of enrollees: the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the date of service and the provider's position thereon.

(2) "Non-Contracted Provider Dispute" means a non-contracted provider's written notice to the plan or the plan's capitated provider challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested or disputing a request for reimbursement of an overpayment of a claim that contains, at a minimum, the following information: the provider's name, the provider's identification number, contact information and:

(A) If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item, including the date of service, and a

clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement of an overpayment of a claim or other action is incorrect.

(B) If the dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the date of service and the provider's position thereon.

(3) "Date of receipt" means the working day when the provider dispute or amended provider dispute, by physical or electronic means, is first delivered to the plan's or the plan's capitated provider's designated dispute resolution office or post office box. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code section 641.

(4) "Date of Determination" means the date of postmark or electronic mark on the written provider dispute determination or amended provider dispute determination that is delivered, by physical or electronic means, to the claimant's office or other address of record. To the extent that a postmark or electronic mark is unavailable to confirm the Date of Determination, the Department may consider, when auditing the plan's or the plan's capitated provider's provider dispute mechanism, the date the check is printed for any monies determined to be due and owing the provider and date the check is presented for payment. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code section 641.

(5) "Plan" for the purposes of this section means a licensed health care service plan and its contracted claims processing organization(s).

(b) Notice to Provider of Dispute Resolution Mechanism(s). Whenever the plan or the plan's capitated provider contests, adjusts or denies a claim, it shall inform the provider of the availability of the provider dispute resolution mechanism and the procedures for obtaining forms and instructions, including the mailing address, for filing a provider dispute.

(c) Submission of Provider Disputes. The plan and the plan's capitated provider shall establish written procedures for the submission, receipt, processing and resolution of contracted and non-contracted provider disputes that, at a minimum, provide that:

(1) Provider disputes be submitted utilizing the same number assigned to the original claim; thereafter the plan or the plan's capitated provider shall process and track the provider dispute in a manner that allows the plan, the plan's capitated provider, the provider and the Department to link the provider dispute with the number assigned to the original claim.

(2) Contracted Provider Disputes be submitted in a manner consistent with procedures disclosed in sections 1300.71(l)(1) -(4).

(3) Non-contracted Provider Disputes be submitted in a manner consistent with the directions for obtaining forms and instructions for filing a provider dispute attached to the plan's or the plan's capitated provider's notice that the subject claim has been denied, adjusted or contested or pursuant to the directions for filing Non-contracted Provider Disputes contained on the plan's or the plan's capitated provider's website.

(4) The plan shall resolve any provider dispute submitted on behalf of an enrollee or a group of enrollees treated by the provider in the plan's consumer grievance process and not in the plan's or the plan's capitated provider's dispute resolution mechanism. The plan may verify the enrollee's authorization to proceed with the grievance prior to submitting the complaint to the plan's consumer grievance process. When a provider submits a dispute on behalf of an enrollee or a group of enrollees, the provider shall be deemed to be joining with or assisting the enrollee within the meaning of section 1368 of the Health and Safety Code.

(d) Time Period for Submission.

(1) Neither the plan nor the plan's capitated provider that pays claims, except as required by any state or federal law or regulation, shall impose a deadline for the receipt of a provider dispute for an individual claim, billing dispute or other contractual dispute that is less than 365 days of plan's or the plan's capitated provider's action or, in the case of inaction, that is less than 365 days after the Time for Contesting or Denying Claims has expired. If the dispute relates to a demonstrable and unfair payment pattern by the plan or the plan's capitated provider, neither the plan nor the plan's capitated provider shall impose a deadline for the receipt of a dispute that is less than 365 days from the plan's or the plan's capitated provider's most recent action or in the case of inaction that is less than 365 days after the most recent Time for Contesting or Denying Claims has expired.

(2) The plan or the plan's capitated provider may return any provider dispute lacking the information enumerated in either section (a)(1) or (a)(2), if the information is in the possession of the provider and is not readily accessible to the plan or the plan's capitated provider. Along with any returned provider dispute, the plan or the plan's capitated provider shall clearly identify in writing the missing information necessary to resolve the dispute consistent with sections 1300.71(a)(10) and (11) and 1300.71(d)(1), (2) and (3). Except in situation where the claim documentation has been returned to the provider, no plan or a plan's capitated provider shall request the provider to resubmit claim information or supporting documentation that the provider previously submitted to the plan or the plan's capitated provider as part of the claims adjudication process.

(3) A provider may submit an amended provider dispute within thirty (30) working days of the date of receipt of a returned provider dispute setting forth the missing information.

(e) Time Period for Acknowledgment. A plan or a plan's capitated provider shall enter into its dispute resolution mechanism system(s) each provider dispute submission (whether or not complete), and shall identify and acknowledge the receipt of each provider dispute:

(1) In the case of an electronic provider dispute, the acknowledgement shall be provided within two (2) working days of the date of receipt of the electronic provider dispute by the office designated to receive provider disputes, or

(2) In the case of a paper provider dispute, the acknowledgement shall be provided within fifteen (15) working days of the date of receipt of the paper provider dispute by the office designated to receive provider disputes.

(f) Time Period for Resolution and Written Determination. The plan or the plan's capitated provider shall resolve each provider dispute or amended provider dispute, consistent with applicable state and federal law and the provisions of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.37, 1371.4 and 1371.8 of the Health and Safety Code and section 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of title 28, and issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the provider dispute or the amended provider dispute.

Copies of provider disputes and determinations, including all notes, documents and other information upon which the plan or the plan's capitated provider relied to reach its decision, and all reports and related information shall be retained for at least the period specified in section 1300.85.1 of title 28.

(g) Past Due Payments. If the provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, the plan or the plan's capitated provider shall pay any outstanding monies determined to be due, and all interest and penalties required under sections 1371 and 1371.35 of the Health and Safety Code and section 1300.71 of title 28, within five (5) working days of the issuance of the Written Determination. Accrual of interest and penalties for the payment of these resolved provider disputes shall commence on the day following the expiration of "Time for Reimbursement" as forth in section 1300.71(g).

(h) Designation of Plan Officer. The plan and the plan's capitated provider shall each designate a principal officer, as defined by section 1300.45(o) of title 28, to be primarily responsible for the maintenance of their respective provider dispute resolution mechanism(s), for the review of its operations and for noting any emerging patterns of provider disputes to improve administrative capacity, plan-provider relations, claim payment procedures and patient care. The designated principal officer shall be responsible for preparing, the reports and disclosures as specified in sections 1300.71(e)(3) and (q) and 1300.71.38(k) of title 28.

(i) No Discrimination. The plan or the plan's capitated provider shall not discriminate or retaliate against a provider (including but not limited to the cancellation of the provider's contract) because the provider filed a contracted provider dispute or a non-contracted provider dispute.

(j) Dispute Resolution Costs. A provider dispute received under this section shall be received, handled and resolved by the plan and the plan's capitated provider without charge to the provider. Notwithstanding the foregoing, the plan and the plan's capitated provider shall have no obligation to reimburse a provider for any costs incurred in connection with utilizing the provider dispute resolution mechanism.

(k) Required Reports. Beginning with the 2004 calendar year and for each subsequent year, the plan shall submit to the Department no more than fifteen (15) days after the close of the calendar year, an "Annual Plan Claims Payment and Dispute Resolution Mechanism Report," described in part in Section 1300.71(q) of this regulation, on an electronic form to be supplied by the Department Managed Health Care pursuant to section 1300.41.8 of title 28 containing the following, which shall be reported based upon the date of receipt of the provider dispute or amended provider dispute:

(1) Information on the number and types of providers using the dispute resolution mechanism;

(2) A summary of the disposition of all provider disputes, which shall include an informative description of the types, terms and resolution. Disputes contained in a bundled submission shall be reported separately as individual disputes. Information may be submitted in an aggregate format so long as all data entries are appropriately footnoted to provide full and fair disclosure; and

(3) A detailed, informative statement disclosing any emerging or established patterns of provider disputes and how that information has been used to improve the plan's administrative capacity, plan-provider relations, claim payment procedures, quality assurance system (process) and quality of patient care (results) and how the information has been used in the development of appropriate corrective action plans. The information provided pursuant to this paragraph shall be submitted with, but separately from the other portions of the Annual Plan Claims Payment and Dispute Resolution Mechanism Report and may be accompanied by a cover letter requesting confidential treatment pursuant section 1007 of title 28.

(4) The first report shall be due on or before January 15, 2005.

(l) Confidentiality.

(1) The plan's Annual Plan Claims Payment and Dispute Resolution Mechanism Report to the Department regarding its dispute resolution mechanism shall be public information except for information disclosed pursuant to section (k)(3) above, that the Director, pursuant to a plan's written request, determines should be maintained on a confidential basis.

(2) The plan's quarterly disclosures pursuant to section 1300.71(q)(1) shall be public information except for the information relating to the plan's corrective action strategies that the Director, pursuant to a plan's written request, determines should be maintained on a confidential basis.

(m) Review and Enforcement.

(1) The Department shall review the plan's and the plan's capitated provider's provider dispute resolution mechanism(s), including the records of provider disputes filed with the plan and remedial action taken pursuant to section 1300.71.38(m)(3), through medical surveys and financial examinations under sections 1380, 1381 or 1382 of the Health and Safety Code, and when appropriate, through the investigation of complaints of unfair provider dispute resolution mechanism(s).

(2) The failure of a plan to comply with the requirements of this regulation shall be a basis for disciplinary action against the plan. The civil, criminal, and administrative remedies available to the Director under the Health and Safety Code and this regulation are not exclusive, and may be sought and employed in any combination deemed advisable by the Director to enforce the provisions of this regulation.

(3) Violations of the Act and this regulation are subject to enforcement action whether or not remediated, although a plan's self-identification and self-initiated remediation of violations or deficiencies may be considered in determining the appropriate penalty.

(n) Non-contracted provider claims payment disputes that have not been resolved by a plan to the provider's satisfaction may be:

(1) Reported to the Department's Provider Complaint Unit for review in identifying unfair payment patterns as defined in Section 1300.71(a)(8). Providers may submit complaints to the Department's Provider Complaint Unit via the Department's web site at http://www.dmhc.ca.gov/providers/clm/clm_default.asp; and/or

(2) Submitted to the Independent Dispute Resolution Process (IDRP) that will be administered by an independent organization contracted or appointed by the Department to administer and fulfill the dispute resolution function established by this subsection (n). The independent organization may, subject to the Department's approval, establish filing fees and a reasonable cost structure for participation in the IDRP.

(3) The independent organization shall, subject to the Department's approval, establish and publish written policies and procedures for receiving non-contracted provider complaints and for resolving non-contracted provider claims payment disputes. These policies and procedures shall include, at a minimum, the following standards and requirements:

(i) A "baseball style" arbitration model, also know as "final-offer arbitration," in which both parties are required to submit their final offer to the arbitrator and the arbitrator must adopt one of those offers as the best approximation of the reasonable and customary value of the services provided;

(ii) If a non-contracted provider elects to participate in the IDRP, the plan and/or the plan's capitated providers shall also participate;

(iii) Before a non-contracted provider can elect to participate in the IDRP, the provider must utilize the plan's or the plan's capitated provider's internal dispute resolution mechanism for a minimum of forty-five (45) working days;

(iv) A non-contracted provider may elect to submit to the arbitrator the original billed amount as the final offer or an alternative amount that the non-contracted provider is willing to accept for the disputed claim(s);

(v) If the non-contracted provider elects to submit the original billed amount as the final offer, the plan or the plan's capitated provider must submit its original claim payment amount plus any additional payment justified by the additional documentation submitted by the non-contracted provider during the plan or the plan's capitated provider's dispute resolution mechanism;

(vi) If the non-contracted provider elects to submit a final offer that is different from the provider's original billed amount, then the plan or the plan's capitated provider may also submit a final offer amount that is different from its prior claim payment amounts;

(vii) To participate in the IDRP, a non-contracted provider must submit a complaint form and a copy of the disputed claim and the supporting documentation previously submitted to the plan or the plan's capitated provider. The non-contracted provider may also submit a narrative justification of his final offer.

(viii) The plan or the plan's capitated provider shall submit its explanation of payment issued as part of the disputed claim's adjudication process, a copy of the Written Determination from the plan's or plan's capitated provider's Dispute Resolution Mechanism, and a narrative justification of its final offer that is not inconsistent with justifications set forth in the Written Determination;

(ix) A non-contracted provider may submit an individual claim to the IDRP or multiple claims that are substantially similar in a single filing. "Substantially similar" claims are those that involve the same or similar services against the same health plan or capitated provider.

(x) After resolving preliminary issues for each claim, including but not limited to the appropriateness of the non-contracted provider's coding and bundling/unbundling of services, the arbitrator shall determine which party's final offer best approximates the reasonable and customary value of the services provided;

(xi) The arbitrator shall make a determination based on the relevant information submitted by the parties within sixty (60) days of the complaint being filed;

(xii) The non-prevailing party shall satisfy or pay the arbitration award within fifteen (15) days of the issuance of the arbitrator's decision;

(xiii) For sixty (60) days following the issuance of the arbitrator's decision, either party may appeal the arbitrator's decision to civil court. Prior to a plan or a plan's capitated provider appealing the arbitrator's decision in civil court, it must pay any amount awarded to the non-contracted provider.

Authority: Sections 1344, 1371.38, 1371.39, 1371.4, Health and Safety Code.
Reference: Sections 1342, 1345, 1346, 1367(h), 1371, 1371.1, 1371.35, 1371.36, 1371.38, 1371.39, 1371.4 and 1379, Health and Safety Code.